Project on
Factors Affecting the Health Situation
of
Slum Dwellers of Bangalore
by
Dr. MANI KALLIATH

(JANUARY - JUNE 1990)

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PROJECT ON

FACTORS AFFECTING THE HEALTH SITUATION

OF

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DEV-170

BANGALORE
SLUMS

HEALTH FACTORS

SOCIAL FACTORS

GOVT SERVICES

NGO SERVICES

C O N T E N T L I S T

B A C K G R O U N D

My involvement with slum dwellers has been through the organisation 'Women's Voice' in Bangalore.

This is a women's organisation attempting to provide a forum to represent the slum women of Bangalore, formed in 1982. Their activists have beenworking with slum women helping to provide organisational inputs, highlight their needs regarding basic amenities, social amenities and stress the rights of working class women. An important area of organisational input is to organise the women by way of their work for example, a union of domestic workers.

The health needs was a priority among the women and hence women's voice had to address this need in some way. I was involved with this group from about 1986 to 1990, with the health workers, working in 7 slums namely Ramanna Garden, Byappanahalli and Lingarajapuram, Lakshmipura, Someshwara of Ulsoor, Luggeri and Jeevan Bheemanagar. Volunteers from slums interested in working among the slum dwellers in the area of preventive and promotive health were chosen and paid an honorarium. They would devote about half a day in this activity, and during remaining time would pursue their other jjobs. Usually two volunteers would be working in one slum community. They would spend their time in visiting rows of houses, giving health education dispensing simple drugs for common ailments and trying to motivate the households for common action to avail basic amenities. Slum dwellers benefitted from the low cost primary health care drugs and health advice made available to them. They found the contacts that the health workers had at the referral centres made access to referral centres easier. In the process of involvement with their community's health needs, their understanding of preventive health, deepened as they analysed the underlying causes of ill health in their community. Hence they began to feel strongly about the organised efforts needed to demand basic amenities and to ameliorate the oppressive situation in which their lives are being lived out. The part time job for many of them began to change into a life's mission.

As is the experience with many community programmes, the diseases preventable by immunization, personal hygiene and safe drinking water are easier to tackle. But problems related to environmental sanitation and malnutrition are difficult to tackle. The answer to these problems involves changes at many levels, for example moving a recalcitrant slum clearance board regarding sanitation. Malnutrition is very much dependent on the earning capacity of the slum household and hence needs the government's will and political pressures to raise their earning capacity. Access to referral centres could be facilitated with certain concerned hospitals and institutions, but their resources are limited in relation to the needs present. But access to government referral hospitals could not be facilitated consistently. This would need policy decisions and pressures from higher levels as well as organised demand from the slum dwellers.

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My training methodology included fortnightly visit to the slum and monthly meeting with the workers in the centre. We gave priority to activities of health post, health education, house visiting, facilitating government health programmes, nutrition supplementation basic record keeping referrals and promoting home remedies. At the slum I would see the patient brought by the workers and suggest remedies through them where possible. I would be involved in the health meeting they organised and I would spend time discussing with the team their experiences and going through their records. Sometimes this would be followed up by a visit to a particular family to reinforce a message or to a government or NGO functionary to build contact and credibility. I often felt overwhelmed or intimidated by the problem situations they recounted, particularly in relation to violence, drunkenness or apathy of government and had doubts about my own effectiveness in the situation.

During the monthly meeting at the centre I had a more positive role to play. My role included facilitating the group sharing and promoting constructive criticisms of each other.

I would give input about a currently relevant health problem and plan with them for future which included efforts to involve resource groups which could help. Facilitating the group process sometimes involved consciously avoiding bringing my values which may be contrary to the group's goals, giving recognition to their efforts and very rarely needing to play the role of a disciplinarian. This process was mutually growing and changing experience in that I learned many things and had to question some of my assumptions, while the team learned information and skills and understanding about group responsibilities. We also developed a mutually respectful relationship.

I would like to put down my significant learnings out of this experience. Most importantly slum dwellers are people with much abilities, character strength and straight forward values. They have the courage to stand up to exploitative forces that appear overwhelming. They have the ability to bear with and smile at the hardships of life. Like the rest of us they have scores of negative qualities also.

Second learning has been that working with slum dwellers is like being in a bottomless pit of expectations and needs. Hence a participatory involvement wherein expectations are reduced would only be practical. There is a need for peer support for oneself in the face of much frustration one is likely to pick up. There is also need for support from tother professional colleagues, and contacts with government functionaries.

Thirdly patience andunderstanding would be a great virtue as there is a time and pace at which significant changes happen in the dynamics of the community. In my opinion the more exploitative vested interests are present the longer it takes for changes.

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Fourthly wider networking and building up of support networks are necessary. This would help for greater strength and clarity of understanding of issues as the problem of slum dwellers is complex. The forces influencing are not only micro level but macro level also and beyond the ability to tackle of an individual or group. Hence sustained efforts need to be directed at overcoming the suspiciousness and insecurity among the activist groups.

I felt the need to get an overview of the factors affecting and the opportunities available for the slum dwellers of Bangalore as I am planning further involvement in the future. I hope this effort would help to add clarity to my colleagues from the voluntary sector working with slum dwellers of Bangalore.

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SUMMARY

Chapter 1 - Introduction

An introductory chapter that outlines the new focus on Urban Slum health and the evolving policy interest among Government, NGOs and others. An overview of the situation in Bangalore is presented from which the broad scope of the study is derived.

Chapter 2 - Methodology and Limitations

This is an interactive study reflection based on interacting with categories of people involved in slums eg. Government servants, NGO persons, activists, slum women. Written materials drawn from different sources also are incorporated. There are various limitations to the study. However, a contribution expected to make is in providing a depth dimension to issues of slum dwellers.

Chapter 3 - Urbanization

Urban population has been increasing faster (21%) than the overall population. This excess is due to new migration and reclassification of settlement. In 1985 the overall slum dwellers population was 35 million. The reasons for urbanization are thought to be both 'pull' and 'push' factors. The rural poor flocking to cities find themselves trapped in urban poverty. 53% of urban population fall below poverty line (CSO 1984-85). The majority of urban poor belong to SC and ST and consist 66% of women and children. Majority of slum dwellers work in the informal sector and there is a high level of child labour. It is estimated that the urban poor have 50% more illness.

Chapter 4 - Slums in Karnataka

Slums in Karnataka can be classified into 3 types of settlements, i.e., around industries, around residential areas and around commercial areas. A study was conducted by S.C.B. in 1984 showing 976 slums and 9.2 lakhs population. The largest share in total numbers and percentages was in Bangalore, next largest proportion is in small towns (less than 50,000).

The number of slums increased by 85% in Bangalore from 1972 to 1982 while the population increased by 75%. Various aspects of the city's slums such as average population size, range of population, space occupied, details of water logging and type of land by ownership, where from migration are happening, income distribution of slum dwellers, educational status of slum dwellers are outlined. Three State agencies are involved in the clearance and improvement of slums in Bangalore with much to be desired in their involvement. Slum clearance board of Karnataka is the primary Government agency for implementation of programmes for basic amenities, resettlement or rehabilitation. However, the SCB is beset with problems and limitations such as a negative outlook towards slum dwellers, limitation in authority to procuring land not including social support in the programmes and corruption.

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Chapter 5 - Factors Affecting Health of Slum Dwellers of Bangalore

The main causes of ill health of the slum dwellers can be grouped under the following headings:

a. Physical factors such as malnutrition, non-availability of protected water, inadequate sanitation and shelter;
b. Social factors such as women's oppressed situation, poor community leadership and dynamics, and psycho-social problems and poor health education.
c. Services - poor access and availability of health services.

a. Physical factors such as malnutrition, non-availability of protected water, inadequate sanitation and shelter

Malnutrition:

High level of malnutrition among below 6 year children are observed ranging from 55% in the moderate to severe malnourished category in the non-ICDS areas and 33.5% in the same category in the ICDS areas. Government intervention come through the nutrition supplementation programmes, among which ICDS is functioning more effectively, and the distribution through fair price shops which programme has much to be desired.

Sanitation :

The sanitary measures available in the slums fall far below the norms established by Government for slum area. Only 25% of households had private toilet, only one source of water for every 53 families and only 57% of hutments had drainage connection to the public drainage. Public toilets are ill-maintained and unusable. The allocation of funds and mechanism for maintenance is poor. There is need for community participation and community education in this area.

Protected water :

The provision and maintenance of schemes for protected water was inadequate even by government norms. The struggle for procuring water for daily needs took much energy of the women folk. Large number of the illnesses of slum dwellers are related to the lack of these amenities.

Housing :

The biggest problem to adequate housing is difficulty in obtaining tenurial rights (patta). KSCB and BDA, main agencies in housing together constructed only 1800 units upto 1984 when the shortage was estimated to be about 60000 units for the slum dwellers of Bangalore. Examples of successful self help schemes suggest that a pragamatic approach may be to provide tenurial rights (patta) and support financially the individual to undertake construction activity.

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b. Social factors such as women's oppressed situation, poor community leadership and dynamics, and psycho-social problems and poor health education

The oppressed situation of women in the slums is a major block to improving the health of the community. They are 'doubly burdened' in being poor and a woman in a strongly male dominated situation. The governmental efforts are not effective in changing this but, often promote this situation. Women's organisation acquiring power though strongly resisted by the male leadership show promise because of their energy and commitment to change their lot.

Leadership and community dynamics :

Leadership that usually exists in the slums is motivated by selfish goals and works in a destructive manner. They hinder development of awareness, block community action and perpetuate a feeling of helplessness. There is no conscious effort by Government in building up community leadership. Similarly the community in general shows passivity and difficulty to be concerned beyond their immediate pressing needs. They also have a poor self image.

Alcoholism is an extensive problem and a priority concern among the women. Apart from the small percentage who are confirmed alcoholics, majority of men consume alcohol in excess. This affects their work, their home relationships and individual health. Consuming alcohol is socially accepted. Government's actions only increase this problems rather than alleviate it.

Health education :

Health awareness of slum dwellers is generally low along with low educational status. Hence effective health education needs to aim at making it possible to change their living situation, apart from learning new information. NGO groups have an important role to play in this.

Chapter 6 - Health Care Facilities in Bangalore

An overview of the various health care facilities in Bangalore is given under the headings of Government, Voluntary and Private Sector. Those facilities that are significant for the urban poor in terms of specifically planned for them or can be availed by them are stressed.

In the government sector specific facilities for the poor are provided by the City Corporation Health department in the form of Mobile clinics, and milk centres and the Central Programme of ICDS. Other facilities that can be availed of includes Urban Family Welfare Centres, Corporation dispensaries, Maternity homes and the sub-centres of PHCs.

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The governmental referral centres are conspicous by their not being trusted by the poor. The quality of service rendered by these groups are discussed, with the inaccessibility of referral centres in general discussed in detail.

The voluntary sector consists of the services of the NGOs (Non-Governmental Organisations) and the Mission Hospitals. The NGO groups are doing service for and have good rapport with slum dwellers. The mission hospitals give some concessional quality care to the poor which has a limited role. In the private sector, the private practitioners play a significant role for the slum dwellers. Their contributions are discussed.

Chapter 7 - Initiatives of the Government

At the national level there has been no policy on urbanization process and problems of urban poor. In the earlier Five Year Plans very little attention was given to urban poor. It was from Sixth Five Year Plan onwards that more focused attention was paid to the urban poor. Relevant aspects of all the Five Year Plans related to urban development and urban poor is traced. The UBS (Urban Basic Services) appear to be a more coherent and comprehensive plan so far. Some of the significant efforts from the States such as 'Skill training programme' of Tamil Nadu Slum Clearance Board, SSEP of Calcutta Metropolitan Authority and the UCD of Hyderabad are outlined.

Conclusion

Summarising the factors resulting in urbanization and the slumming process. Idea's and viewpoints arising out of the experience of the writer in relation to Bangalore slums are summarised. They relate to government departments concerned with slum dwellers, vulnerable segments among slum dwellers and NGOs working with slum dwellers.

C H A P T E R I

Introduction

The slums and urban poor have gradually been moving into the focus of attention of the local government and the general public. There is a realization that slums and slum dwellers have been excluded from the planning process of the government both state and central. As a result of this an 'urban crisis' has developed represented by a quarter or more of urban population living in inhuman conditions related to shelter, health and social amenities and supports. This is specially so in the major metropolitan cities of India. There is some international interest in this area with some involvement by agencies like UNICEF, ODA (Britain) and World Bank in efforts of imaginative planning to tackle this problem. There is as yet very little commitment to long term policy changes from international bodies, but their involvements seem to be in the nature of 'pilot' programmes.

This gathering of interest has had an awareness building influence on the government of Karnataka. The Government's public stance on slums is changing from 'An illegal encroachment to be demolished and cleared and the problem will disappear' to a recognition that they are made up of people who cannot be wished away but have to be provided for in some way.

However, the understanding on government's part appears to be simplistic without recognising the wider factors involved or being sensitive to the pressing needs of the people. Hence governmental actions are constrained by sectoral boundaries and bureaucratic compartmentalisation as well as by disinterest and inadequate planning and fund allocation.

There is an awakening among the NGOs of the State to the pressing needs of this sector. Regional and State seminars are focussing attention on this theme. There is a mushrooming of social work organisations in the urban areas working on different aspects of this problem. However in my opinion the NGO efforts are hampered by inadequate understanding and preparation. Many NGOs seem to be bogged down at the level of programmes and activities directed at a few problems, while the overpowering magnitude of the problems of slums and slum dwellers remain to be tackled. In addition inadequate networking among NGOs has tended to limit understanding and effectiveness. At the same time politicians and their interests continue to manipulate and oppress slum dwellers through the local exploitative leadership of slums.

Bangalore the most populous city of Karnataka has seen phenomenal growth in urban population and slum population. Bangalore had experienced the fastest growth rate among cities in India in the decade 70 - 80. Though researched data is not available it is believed by people working with slum dwellers that there are 600 slums in Bangalore and about 10 lakhs of people living in them comprising more than 20 percent of the city population (accommodation of Indian slums TCPO 1985). The health status of Bangalore

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slum population expressed as IMR(Infant Mortality Rate) show a considerably poor status. The IMR of slums of Bangalore is thought to be about 120, whereas the IMR of Karnataka urban is 46 (sample registration bulletin - June 1990).

The level of malnutrition among children below 6 years especially of the moderate and severe category as recorded by the city ICDS programme is 33.5%, though an NGO programme working with slum dwellers estimates it about 50%. When we try to get beyond the indices to the situation of their lives, we find it a story of deprivation, exploitation, insecurity, violence, squalor and inhuman living conditions. There is no possibility of dignified human living.

There appears to be a need to get an overview of the reality situation of the slum dwellers of Bangalore and what government and non-governmental agencies are doing in this situation and what are the hopeful signs in the horizom. My interactive study reflection is an effort in this direction. There is need for much scientific study into various aspects of this situation as well as documentation of NGO efforts among Bangalore slum dwellers.

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C H A P T E R II

Methodology and Limitations

A. Methodology

My study is based on discussions and interviews with various groups of people involved with slum dwellers of Bangalore and from studying written literature on the problems of urban slums. I started with the goal of getting an overview of the existing situation of the slum dwellers of Bangalore and due to a time constraint decided against any formal surveys. I used an interactive approach, interacting with a large number of people involved in slum work (refer list below) and have built up an overview from these interviews in a participatory way. Hence this is an interactive study reflection which will be referred to as 'study' in this chapter.

The people I interacted with were chosen from the following categories :

a. Government

   i. Functionaries of the corporation health department involved with their various health institutions;
   ii. Functionaries of the slum clearance board;
   iii. ICDS planning and statistics.

b. Key persons from NGO groups involved with slum dwellers;

c. Grass root level activists of a women's group working with slum dwellers, and

d. Group of slum women.

Though I prepared an interview schedule for each group, while actually discussing I have not stuck to the schedule but was guided by it. I kept notes of my interviews and discussions and utilizing them while writing the report and have indicated whenever relevant. The 'Background' chapter explains my motivation for this study. The chapter of summary gives chapterwise summary of the report. In chapter III - Urbanization and chapter IV - Slums in Karnataka, I have drawn heavily from reading materials indicated. In chapter V - Factors affecting health of slum dwellers of Bangalore and chapter VI - Health care facilities available, as mentioned earlier, I have not been able to include any formal survey data. Chapter VII - Initiatives from the recent past, I have drawn heavily from reading materials indicated. The conclusion chapter lists the conclusions that I have drawn guided by my 4 years (1986-1990) of involvement with slum dwellers. They are not based only on the understanding gained during the study period (February 1990 to July 1990)

There is a year and a half gap after the completion of the study and bringing out of the report, due to my taking up an assignment in another State. Hence this study has to be read in the perspective of early 1990.

B. Limitations

There are several limitations to this interactive study reflection :

1. I did not undertake collection and analysis of first hand data as mentioned in the methodology.
2. Questionnaire schedules were tentative and got changed on the experience of initial interviews.
3. Many interviews especially of the NGO groups lead to only general impression and conjectures as accurate records were not available.
4. Certain information taken from records of the organisation 'Women's Voice' or from the corporation mobile team will only indicate trends, as the records were not maintained for a scientific study.
5. Whenever I have given rough percentages on data about Bangalore these were based on the interviewer's estimates and hence need not be accurate.
6. In the slums only women's groups were interviewed for lack of time and opportunity. These were groups that came voluntarily for discussion through the contact of the local health workers of women's voice. This may therefore be a self selected sample.
7. Similarly the NGO groups and activists interviewed were my selection based on groups known to me or my immediate contacts and from those who responded to my requests.

Hence this interactive study has to be viewed as a preliminary overview highlighting areas and issues to be scientifically studied further. This is an attempt to explore the multiplicity of factors affecting the health, health care accessibility and utilization pattern and other related issues affecting slum dwellers of Bangalore. Inspite of the absence of hard data this preliminary interactive study reflection has helped to identify issues and perspectives on these issues from various groups. These are often missed due to the dynamics of a formal study. The interactive study reflection seeks to make a small contribution in building an indepth understanding of the complexity of the problems.

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C H A P T E R III

Urbanization

Process of Urbanization

All over the world population is increasing in the cities and towns at a faster rate than in the rural areas. The number of towns and cities keep increasing and so do the number of metropolises with over a million population. Along with these increases in urban population the number of slum settlements and people living in them increase. It is the assessment that the population living in slums grows even at a faster pace than the rest of the city.(1) This large increase in numbers of both urban rich and urban poor, brings about a crisis situation. The infrastructural facilities especially housing, water and transportation, are already inadequate to meet the needs of the cities. The worst sufferers in this situation are the poor who get locked out of the basic needs of life.

In looking at this process of urbanization at the national level certain patterns are visible. According to some estimates the number of towns and cities increased from 2330 to 3245 during the period 1961-81 all over India. During the same period the urban population increased from 77.6 million to 156.2 million (2). The increase in urban population was 21% greater than the increase in overall population. This is seen to be 41% due to natural increase, 38% due to in-migration and 21% due to reclassification of settlements. Out of this urban population 60.4% are residing in 216 cities and they accounted for 69% of the urban population increase. In 1985 the official total slum population was estimated as 35 million which works out to about 20% of the urban population. However, in the larger metropolises the population living in slums is greater around 30% or more and is growing faster than the rest of the urban population. Greater increases in the slum population are seen apart from the metropolises in the towns of less than 50,000 population

The reasons behind urbanization are said to be of two types - pull factors and push factors. The pull factors are the greater job opportunities in towns and cities due to industrialization and locating of industries in urban and peri urban areas and greater investments in service and other sectors. The glamour of city life and the promise of better life is another pull factor. The push factors are those that make life conditions difficult and miserable especially for the rural poor. These are the decreasing annual employment and diminishing real wage rate for agricultural labour, displacement by massive developmental projects, droughts, floods, and resulting low earnings from land, wars, terrorism and social oppression. Hence increasing rural poverty forces people

(1) National Commission on Urbanization Report 1988
(2) National Commission on Urbanization Report 1988

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to migrate for survival. In this process man made decisions or political decisions seem to be playing a major role both in the degradation of the environment and in the reasons for the rural poor becoming poorer.

The rural poor apparently decide where to migrate based on kinship ties in the city, perception of job opportunities and nearness to their place of dwelling. Having reached the city or town they do not find an easy answer to their problem, but could be in a worse situation than the original problem. They initially stay with kins until they have a better grasp of the city. Soon the experience is that though their earning is relatively higher as compared to the rural situation their poverty is greater. This is because in the urban cities they have been locked out of better jobs, from procuring decent dwellings, accessing services of education and health but forced into a situation of stress, hunger, violence and human degradation.

To the casual observer or to an old resident of the city the slums may appear to be unpleasant outcroppings to be avoided. No further understandings are developed regarding life styles and deprivations and needs of the slumdwellers. Often slum dwellers are perceived as possessing various negative qualities of character and behaviour and there is some rationalization to keep this perception unchanged.

Urban Poverty

Majority of urban poor live in the slums. The majority of slum dwellers are living below the poverty line. Poverty line is defined by the planning commission as the 'midpoint of monthly per capita expenditure class having daily calorie intake of 2140 calories per person in urban areas or 2400 calories per person in rural areas', in other words they are not able to spend enough to obtain 2140 calories of food daily per person. This definition does not take into account the other areas of deprivation namely of basic neccesities of adequate shelter, healthy environment and water or of ability to procure social services of education, health or the psychological deprivation of an outcast. As per the definition of calorie intake 53% of the urban population fall below the poverty line according to the estimate of Central Statistical organisation 1984-85 having a per capita income below Rs.136.75 per month (See Table I).

On further analysis it seems that over 40% of these poor belong to scheduled castes and scheduled tribes which is much higher than in general population. The status of women and children who make up 66% among the urban poor is worse than the men, as men generally have the first preference in food and spending of money in slum areas. This picture of poverty is reflected in the aspects of quality of dwelling, environmental sanitation, educational status. Over 90% of the people in low income areas live in kucha or semi pucca dwellings, literacy rate of slum dwellers is estimated at

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stimate of Poverty 1984-1985 by NSSO and CSO

ear	Poverty Ratio		Per Capita per month / Poverty line income	
	NSSO	CSO	NSSO	CSO
984-85	0.28	0.53	122	136.75

ource: NIUA, New Delhi, 1988

26% and 50% slum dwellers use open areas for cleaning their body(1)

Majority of the slum dwellers work in the informal sector as construction workers, domestic help, casual labourers, petty vendors or in recycling waste. (2) There is a high level of child labour supplementing family income which form about 7 - 9% (3) of all employed, among whom 70-80% are boys. Their occupations carry higher levels of risk from accidents, pollutions and exploitations. There is hardly any education in prevention of such risks made available to them.

Health of the Urban poor

It is estimated that the urban poor have 50% more illness than the rest of the population. This is probably a conservative figure as good records are not available. However, the conditions prevailing in their work and dwelling places are such as to promote a great variety of diseases, namely, industrial pollution, overcrowding, unsafe water and inadequate sanitation. However their access to health information and health facilities are quite low inspite of the variety of health care facilities available in the cities.

Infant mortality rate in slum areas is thought to be over 120 per thousand live births, number of children turning blind due to Vitamin A deficiency yearly is 6000, diarrhoeal incidence is 500 per thousand infants and 299 per thousand among pre-school children. There is a large increase in urban malaria. The occurrence of TB and respiratory diseases are high, with increase in the number of TB deaths. 29 percent of infant deaths and 22 percent of child deaths occur due to lack of trained medical attention. Only 8-10 percent of the urban population have underground sewer and 35% have access to sanitary facilities (4). Only 15% of children in slums are considered to have normal nutritional status (5), 50% of expectant mothers suffered from nutritional anaemia resulting in low birth weight babies (6). There is a growing sense of hopelessness, high rate of consumption of alcohol, high crime rate and group violence

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(1) National Commission on Urbanization Report 1988
(2) National Commission on Urbanization Report 1988

(3) Source : NIUA 1988, Who the poor are, What they do, Where they live
(4) Source : NIUA 1988, Who the poor are, What they do, Where they live
(5) Seventh Five Year Plan document
(6) S.D.Singh and K.P.Pothar, 1982

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C H A P T E R IV

Slums in Karnataka

An Overview

In Karnataka we can classify three distinct patterns of slum settlements :

1. Industrial slums located in and around major industrial areas;
2. Service slums located in and around residential areas which is inhabited by people who make a living by working as domestic servants, house keepers, peddlars, etc.;
3. Commercial slums which abound near and around commercial complexes or office complexes, people from these slums rely mainly on informal sector for their income.

A study conducted by the Slum Clearance Board of Karnataka (SCB) in 1984 had identified 976 slums in the State. Of the 976 slums identified 590 were declared officially as 'authorised' under the provisions of the Slum Clearance and Improvement Act. Between 1977 and 1984, the slums population has increased from 800,000 to 922,000. The 590 slums had about 546,000 persons. About 50% of the slums were located in class I cities of the State(i.e., cities with population more than 100,000) and Bangalore alone accounted for 23% of the slums and 45% of the slum population (1977). But in 1984 the Class I cities alone accounted for almost 70% of all slums and 80% of slum population. Bangalore alone increased within the span of seven years to 41% of all slums and about 54% of slum population in the State. (1).

It should be noted that although in terms of absolute numbers the slum population in small towns is not considerable, the percentage of slum population is comparable to that of large cities. In fact, after the metropolitan city of Bangalore, the next largest proportion of slum population is found in towns of less than 50,000 population. This suggests that the rural migrants prefer centres of largest opportunity and also centres of proximate opportunity. Thus, moving to far off places is kept only as a last resort when all options are closed. It is also observed that the largest proportion of the slum population is concentrated in those cities that are multifunctional with industrial base, rather than those specialised only in industrial base. Bangalore city satisfies all these conditions and hence has a high rate of increase of slum population. (1).

Slums in Bangalore : Size and Growth

Bangalore the capital city of Karnataka, was the fastest growing city in India in the decade 70-80s. (2). The slum population in Bangalore also has been growing very fast as will be seen in the figures given below. The infrastructural facilities of water, housing, sanitation and transportation have become inadequate for the needs of the people. The planners have not begun to address this boldly.

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1. Karnataka State of Environment report 1984-85
2. Urbanization Policy for Karnataka Interim Report

A study of Bangalore done in 1979 throws some light on the size and growth of the city. This excerpt is taken from Ramachandran's analysis of this study in 'Slumming of a Metropolis'. The Bangalore City Corporation contained 159 slums in 1971-72 with a population of about 1.3 lakhs accounting for about 10% of the city population (Structural Analysis of a Metropolis - Bangalore - 1979 - V.L.Prakasa Rao and V.K.Tiwari) whereas the average slum population in cities with a population of over a million is estimated to be 17% (NSS, 1980). The number of 'declared slums' in Bangalore increased from 159 in 1972 to 287 in 1982 i.e., an increase of about 85% and identified slums (including undeclared ones) are estimated to be 420 in 1984. Rough estimates put the slum population at 7.3 lakhs out of 29 lakhs in 1981 i.e., about 25%. Further predictions say it will have 10 lakhs slum dwellers out of a total population of 43 lakhs at the end of 1990 (about 30%). (3). These studies also estimate that the average population size of a slum was little over 500 persons. However, the range in size was between 34 to 9000 persons - the most frequent size being 300-600. Slum areas in the city centre occupy less space mostly single room residences; whereas slums in the periphery occupy more space. About 9% of the slum area in Bangalore containing 42% of the city slum population was reported to be water logged during monsoon. In the case of other class I cities the corresponding figures are 47% of the area and 51% of the population. This is natural because slums have come up in degraded land i.e., low lying near tanks, flood drains, or near to city dumps.

All four categories of land have seen sprouting of slums i.e, corporation, government, B.D.A. and private lands of absentee land lords. Slums in private lands show maximum increase (Table 1b) Among the three zones of the city i.e., core, intermediate and outlying, the intermediate zone has registered maximum increase. This could perhaps be explained by the fact that at an earlier time the intermediate zone was the periphery of the city.

The characterstics of the slum population brought out by the same study shows :

1. The largest portion of the slum dwellers have come from Karnataka State, with migration from the northern districts happening more recently. The other southern states have contributed sizeably to the slum population (Table - 2).

2. The monthly income of the slum dwellers showed considerable differences from that of the non-slum dwellers as can be expected from the fact that they are dependent on low paid, low status jobs in the informal sector (Table - 3)

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(3)'A compendium on Indian Slums TCDO, 1985

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Distribution of Slums by ownership of land (Karnataka, 1977)

Ownership	Per cent oto total slums		
	Declared	Undeclared	All slums
Private	40.3	21.4	35.6
Government	10.7	11.2	10.9
Defence	0.2	-	0.1
Local bodies	18.5	27.0	20.6
Public Undertakings	1.8	1.0	1.6
Others	28.5	39.4	31.2
	100.0	100.0	100.0
Total	(596)	(196)	(792)

Source : Karnataka State of Environment Report.

T A B L E 2

Percent distribution of migrants in slums and non-slum areas by origin

Origin (States)	Slum areas	Non-Slum areas
Andhra Pradesh	15.0	7.6
Karnataka	46.0	57.9
Kerala	1.1	8.1
Tamil Nadu	36.4	21.3
Others	1.5	5.2
Total	100.0	100.0

Source: Karnataka State of Environment Report, 1984-85

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T A B L E 3

Percent households by income groups in slum and non-slum areas 1976

Income per month (in Rs.)	Slums	Non-Slum areas
Below 300	80.2	24.4
300 - 500	16.6	27.0
500 & Above	3.2	48.6
Mean income per household	206.32	657.3
Monthly per capita income	34.91	133.0

Source: Prakash Rao and Tiwari (1976)

3. Hence their participation in the workforce was larger than in the non-slum areas with children forming 7-9% of the workforce.

4. The educational status of the slum dwellers is considerably poorer than the non-slum dwellers (Table - 4).

5. The health status of the Bangalore slum dwellers is believed to be similar to slum dwellers in other cities of India, however no accurate studies are available about Bangalore. The important factors affecting the health of Bangalore slum dwellers is looked into in Chapter V.

With the help of the sample study quoted above certain inferences can be drawn about Bangalore slum dwellers. However, it has been my experience that no comprehensive enumeration has been done about the slums and slum dwellers, especially so about unrecognised or illegal slums.

Slum Clearance and Improvement Programmes

Three state agencies are involved in the Clearance and Improvement of slums viz., Bangalore Development Authority, City Corporation of Bangalore and Slum Clearance Board of Karnataka. The social amenities are being extended through other departments. Since the responsibility of basic infrastructure for slum dwellers rests with three agencies that has given ample scope for the complete ineffectiveness of their carrying out any meaningful developmental programme in any of the slums. These agencies pass on their responsibility to the other with the result no one takes responsibility for the immediate work to be carried out or to maintain the facilities provided, if any. Interestingly each of the three agencies do not necessarily recognise the authorisation of the slum by other two agencies so as to provide facilities and amenities. This completely brings in a double burden on the slum dwellers to prove their tenure to each of these agencies in order to receive facilities from them. Also they have rigidly limited their definition of responsibility to dwellings and physical infrastructure, except for the corporation areas.

Slum Clearance Board of Karnataka

The Slum Clearance Board of Karnataka was established in 1975 with the following major objectives :

a. take up projects to improve environmental conditions in slums;
b. protect the bonafide slum dwellers from eviction by the land owners;
c. construct tenaments for slum dwellers; and
d. clear unauthorised huts and prevent emergence of new slums.

The Karnataka Slum Clearance Board limits its activities only to the slums in private and government lands, railway and muzrai land. Bangalore Metropolitan Area among all the cities in the State account for the largest number of slums. There are 401 slums

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TABLE 3b

Distribution of households by monthly earnings in Bangalore

Earnings Range (in Rs.)	Total Households (Nos)	Percentage to total Households
Below 300	274	9.08
300 - 500	1446	47.96
500 - 700	768	25.47
750 - 1000	315	10.45
1000- above	212	7.04
Total	3015	100.00

Source : A study for the formulation of Poverty alleviation programmes for Urban Slums, NCHSE, 1987.

TABLE 4

Literacy rate in slums of Bangalore

Particulars	Slums	Non-Slums
Literacy	47.3%	79%

Source: Education in Slums, A.S. Seetharam, 1983

identified by Karnataka Slum Clearance Board consisting of about 3.65 lakh population and they are located on lands belonging to various authorities and private individuals as noted below.

a. On B.D.A. Land	64	
b. On City Corporation Land	64	
c. On Government land and private land	165	KSCB
d. On Railway, muzrai, etc.,	108	KSCB
Total	401	

This list includes only slums in the process of recognition. KSCB limits its activities to 273 slums only. However, other estimates put the number of slums at over 600 with a population nearing 10 lakhs slum dwellers (A compendium on Indian Slums TCDO 1985)

Programmes implemented by the KSCB (as per their report)

1. Providing basic amenities like roads, surface drains, street lights, drinking water, community latrines/bath rooms.
2. Resettlement of the slum dwellers in the same area by constructing houses/tenaments.
3. Rehabilitation of the slum dwellers in a new place, after creating the required facilities.

Since inception in Bangalore Metropolitan Area basic amenities have been provided to 94 slums incurring a total expenrditure of Rs.120.80 lakhs. Resettlement of the slum dwellers in the same area has been taken up in 13 slums incurring a total expenditure of Rs.233.85 lakhs and 1754 houses/tenaments have been constructed with the loan assistance from HUDCO. (3b).

Civic amenities

The main objective of the Board is to provide basic amenities to all the slums in a phased manner. As against 1270 slums identified by the Board in the State, 671 slums have already been covered by providing basic amenities at a cost of Rs. 898.49 lakhs upto end of March 1989.

Drinking water

In the usual improvement works there is a provision of providing drinking water facilities to all the slums. In addition to the above schemes, the Board is intending to take up sinking of borewells and repairs to the existing borewells to meet the scarcity situation especially in summer season.

Statistics on basic amenities provided so far are listed in Table 5.

(3b) Report on the basic amenities and housing programmes of KSCB - Annexure 1 & 2 - Secretary 3.2.90

T A B L E 5

Targets and achievements in Environmental Improvement Programme of Slums in Karnataka (VI Plan Period)

Year	Physical target (population)	Plan allocation (in Lakh Rs)	Expenditure (in lakh Rs)	Physical achievement (population covered	No. of slums covered
1984-85	63,200	158,00	101,60	68,450	93
1984-85*	44,000	110,00	67,12	84,301	87
Total		268,00	168,72	152,751	180

* Central Incentive Scheme

Targets and achievements in construction of tenaments for slum dwellers in Karnataka

Year	Target		No. of tenaments constructed	Amount spent		Total
	Phy	Fin (in lac Rs.)		State funds	HUDCO	
1983-84	2,500	26.50	1200	70.50	57.12	127.62
1984-85	5,636	160.00	1992	21.79	87.14	108.93
Total	8,136	186.50	3192	92.29	144.26	236.55

Source : Karnataka State of Environment Report, 1984-85.

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KSCB - Problems

The Slum Clearance Board of Karnataka (SCBK) is beset by many problems and limitations. At an attitudinal level the KSCB which represents the government's response to the problems of slums appears to view their responsibility as "slum dweller's problem". This is contrary to the emerging recognition among policy makers and academicians that growth of slums is a corollary of urbanization process. The non-slum population is as much responsible for this situation as the slum dwellers. Until very recently there was no representation in the board from the slum communities. The relationship of the board with the slum communities has been a negative one, with KSCB looking down on slum dwellers.

The Board is limited in its authority. It has no powers to procure land for disbursement. There are difficulties in getting cooperation from the other government agencies involved. It has been pointed out that there is no representation of the Board in the BDA which controls land development in Bangalore city. Lack of legal authority comes in the way of their activities in certain slums in private lands, where land lords have taken legal recourse.

The Board functions as though it is a disbursement agency for funds rather than a s an agency that looks after and plans for the welfare of the slum dwellers. Hence the programmes of KSCB relate to development of infrastructure like roads, pavements drains, toilet, water sources etc., but not to social supports like health, schooling, community building. Once the programme is carried out the Board expects other agencies to take over the maintenance which does not happen in reality. The Board does not take any responsibility for large number of slums that come under the category of unrecognised or illegal slum, though they may be in existence for several years. Their requests for recognition is addressed very slowly, taking decades to be processed.

There is inefficiency and corruption in the implementation of the plans of the Board, however, inadequate they may be, for example housing targets drawn up by the Board have not been met and the quality of constructions is very poor.

Bangalore Development Authority

There is no particular focus in BDA for slum dwellers. Certain Ad-hoc programmes for slum improvement and housing is carried out by BDA.

Bangalore City Corporation provides services to the slums coming under their jurisdiction for health and slum development. No housing construction is undertaken by Bangalore City Corporation.

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C H A P T E R V

Factors Affecting Health of Slum Dwellers of Bangalore

The W.H.O. definition says that health is not only the absence of disease but a state of physical, mental and social well being. All factors that affect physical, mental and social well being affect the health of the individual. In Bangalore slums as is true in the rest of the country the important factors affecting health are outlined below. A major contributory factor is also unavailablity of health services. This will be looked at in detail in Chapter VI.

A. Physical factors

1. inadequate nutrition from poverty
2. inadequate availability of protected water
3. inadequate facilities for sanitation and toilet
4. inadequate shelter.

B. Social factors

1. women's oppressed situation
2. poor community leadership and community dynamics
3. psycho-social problems like alcoholism
4. poor health education.

The health status of a community is commonly expressed with the help of certain indices of which Infant Mortality (IMR) is considered a sensitive index.

The IMR for Karnataka Urban in 1988 was 46 (sample Registration Bulletin - June 1990). In the slum areas of the country, it is thought to be over 221 (specific IMR for Karnataka slums is not available). Unacceptable though this situation is, it is not surprising given that population living in slums though near to civic amenities physically, is locked away from all amenities and services.

Inadequate nutrition from poverty

Majority of slum dwellers earn extremely low income and can be considered as below poverty line (Table 3, Chapter IV). Hence they are not able to procure the food items needed for a balanced diet and adequate nutrition. This inspite of the fact that 70% of their income is spent on food (Table 6). Malnutrition is noticeable in the form of stunted growth of children. Children below 6 years are particularly at risk. In moderate and severe forms it predisposes to a variety of sickness. Malnutrition among pregnant mothers causes a variety of problems such as birth of low birth weight babies and their susceptibility for illnesses and high rate of illnesses and deaths among pregnant women and mothers.

(a) Urbanization and its implication for child health WHO, Geneva, 1988

It is easy to measure malnutrition levels among 0-6 years age children by their weight compared to a national average. It is seen that in slums without any nutritional interventions only 15% of children are in the normal category and 30% of children in the mild malnourished category. About 50 to 55% of the children are at risk due to moderate to severe malnutrition (Table 7). Where nutrition intervention are regularly taking place as in the ICDS areas the level of moderate to severe malnutrition is 33.5% (Table 8). Hence it is not surprising that children of slum dwellers suffer from high incidence of diarrhoea dysentries, acute respiratory illnesses and nutritional diseases and skin infections such as boils (Table 9).

The interventions by the government in this area come under two categories :

1. Nutrition supplementation of below 6 year children and pregnant and lactating mothers

   a. special nutrition programmes
   b. ICDS programme
   c. Vitamin A administration against nutritional blindness and prophylaxis against nutritional anaemia.

2. Food items under controlled price distributed through fair price shops.

Nutrition supplementation of below 6 year children and pregnant and lactating mothers

a. Special nutrition programme is carried out through nutrition centres and/there is a food distribution programme under the department of Women and Children's Welfare. It is distributed through honorary local persons of the slum areas who are paid a small honorarium. Distribution is done at a specified time every day and consists of a 200 ml milk and two slices of bread. There is no system of enumerating beneficiaries, monitoring utilization of the services of providing health services to the beneficiaries. This programme is available in majority of slums, though not very effective in implementation.

b. ICDS will be looked at in more detail in Chapter VI. Here I am restricting my attention to the nutrition component of the programme. There are two ICDS programmes in the city totally covering a population of 2 lakhs from the slums and low income groups, spread out in about 200 centres. There are about 15,500 children in the age group 0-6 who are beneficiaries. 46% beneficiaries are slum children who are benefitting from this programmes. There are 52 slums in which ICDS centres are

T A B L E 6

Expenditure pattern of slum households

Item	Percentage of income Spent
Food	70.3
Fuel	10.5
Clothing	7.0
Health	3.3
Rent	0.9
Others	8.3

Source - H. Ramachandra - Slumming of a metopolis

T A B L E 7

Malnutrition levels of Children from Slum Areas

Normal	First Degree	Second Degree	Third Degree
15%	30%	25%	30%

Source : From the records of Women's Voice health programme in Seven slums of Bangalore, 1989-90.

T A B L E 8

	Total Children Weighed	Normal	1st Degree	2nd Degree	3rd Degree
Number	15225	3979	6139	4952	165
Percentage	100	26.0	40.0	33.0	1.0

Source : Oral Communication with Project Officer ICDS Urban Bangalore 1990.

TABLE 9

Breakdown of the Diseases treated by one Mobile Health Team of Corporation during the Month of June 1990 in the Twenty One slums covered. This is given according to the order of highest occurrence.

	Male	Female	Child	Total
A. Fever	93	85	106	284
B. Arthritis	84	76	--	160
C. Diarrhoea/Enteritis	31	44	66	141
D. Bronchitis	19	26	37	82
E. Other Respiratory Illnesses	21	35	19	75
F. Bronchial Asthma	38	27	-	65
G. Dysentry	11	14	38	63
H. Skin Diseases (other than boils, abscesses, cellulitis)	9	13	32	54
I. Diseases of stomach and Duodenum)	14	19	21	54
J. Helminthiasis (other than ancylostomiasis)	-	8	35	43
K. Ancylostomiasis	2	6	12	20
L. Enteric Fever	2	4	9	15
M. Acute Tonsillitis	-	-	14	14
N. Boils, Abscess, Cellulitis	-	4	6	10
O. Glossitis	-	6	4	10
TOTAL	324	367	399	1090

A casual analysis seem to point out that most of the health problems of the people who sought treatment relate to poor environmental sanitation, poor personal hygiene, malnutrition and lack of safe water.

The diseases C - Diarrhoea/Entertitis, G-Dysentry and L-Enteric Fever which could be directly attributed to inadequacy of protected drinking water account for about 20% of the illness. If to this is added J - Helminthiasis, K-Ancylostomiasis and N-Boils etc., the percentage rises to close to 30% which conditions are related to poor environmental sanitation. The category A-Fevers and D-Bronchitis and E-Other Respiratory Illnesses, though comprising of varied illnesses in children have a strong relationship to malnutrition. This group would constitute another 15%.

Since detailed diagnosis is not available for the other categories of symptoms like A-Fever, B-Arthritis, it is difficult to comment on their cause. Hence going by identifiable diagnosis alone about 45% of the symptoms were due to the primary factors of malnutrition, poor environmental sanitation and unprotected drinking water.

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located. Children are distributed food items in the following manner :

i) below 1 year - 225 ml of miltone (fortified milk)

ii) 1-6 years - 110 ml of miltone + 2 slices of bread severely malnourished.

iii) 1-6 (Grade 3-4) - 225 ml of miltone + 4 slices of bread

For pregnant and lactating mothers 225 ml of miltone, 4 slices of bread.

Cost Rs.0.75 per head and Rs. 1.50 pr head for malnourished children.

ICDS programme is functioning reasonably well in the slums where centres are present.

c. Vitamin A and iron administration is being done through the health extension workers. This is carried out by both the health workers of the PHC (Primary Health Centre) subcentres and by the Anganwadi workers for the children enrolled in their centres.

Fair Price Shop system (ration shops) :

It is roughly estimated that about 75% of the families are ration card holders. The quantity of items available for a family of 5 members is as follows per month :

1. Rice 14 kg at Rs. 3.25 per kg
2. Wheat 5 kg at Rs. 3.25 per kg
3. Soji 5 kg at Rs. 2.75 per kg
4. Maida 5 kg at Rs. 3.00 per kg
5. Sugar 5 kg at Rs. 5.25 per kg
6. Oil 1 kg at Rs.18.75 per kg
7. Kerosene 16 litres at Rs. 2.50 per litre.

Ration is distributed twice monthly and kerosene is distributed weekly once,all on fixed dates.(1)

As per the requirement of balanced vegetarian diet (Diet Atlas of India, N.I.N. 1971, Table VI-A) for 5 persons per month calculated comes to :

1. Cereals (Rice, Wheat, Soji, Maida) - 55 kg
2. Sugar and Jaggery - 6 kg
3. Fats and Oils - 5 kg
4. Pulses - 10 kg
5. Vegetables - 15 kg.

Apart from other items like milk, fruits, leafy vegetables. Hence controlled price supply is nowhere near to meeting the requirements of the families.

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(1) obtained from activists of Women's Voice, June 1990

There are many difficulties associated with the ration shops, namely long queues with stock running out for later ones in the queue, not having enough ready cash to purchase the items on the fixed day and hence losing the rations, the quota of rice is generally adequate only for half the days after cleaning out the stones and broken rice, while kerosene is adequate for half the days.

What is not adequate has to be bought in the open market where prices are often more than double. With the high cost of kerosene in the open/black market it is prohibitive to buy for the slum dwellers. It is mainly used for the oil lamp, and cooking once a day when possible. Another fuel purchaseable is, waste wood which is used as fuel when kerosene prices are prohibitive. Except rice, wheat and kerosene other items generally are not purchased by slum dwellers for lack of ready cash. (2).

Hence the food prepared consists mainly of cereals with a small amount of pulses in the 'sambhar'. Vegetables in tiny amounts add taste to the sambhar. When the luxuries of sambhar are not possible food is rice or ragi with a chilly pickle. Women generally cook once a day in the evening and make do with it in the morning and also for feeding the children. In those small instances when food is packed for the husband to work, cooking is done in the morning also. Hence it is common for slum women to make do upto noon with a cup of tea and betel leaf and tobacco which cuts the appetite. It is not uncommon for women and girl children to eat after the male members have eaten. Hence their share of the family food could be even less.

In the village of origin of many of the slum dwellers, there are cultural traditions of cooking which have much value. Village cooking traditionally has chutneys and powders made from pulses, groundnut, tamarind and greens such as gongura along with chilly. These keep for long time and nutritionally help to balance the diet. Urbanization bringing about clutural alienation also affects food preparation patterns. People have scientifically unsound beliefs regarding superiority of certain types of food stuffs, for example rice being superior to ragi, or in earlier decades the popularizing of milk powder over breast milk.

Unaffordability of food both in quantity and quality, is a general statement about the slum dwellers. The emaciated bodies of the adults, pot bellied thin limbed and pathetic looking children bear witness to this statement

Inadequate availability of protected water

Water in adequate amounts and adequately protected is necessary for cooking and drinking and for washing and bathing for every human being, for survival and good health. Park's Text book of Preventive and Social Medicine says :A daily supply of 150-200 litres of protected water is considered an adequate allowance per head. Water

(2) Discussions with Women slum dwellers - June 1990

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Mission has adopted as its objective supply of 40 litres per capita per day of protected water. The present rate of supply of water in Bangalore is about 65 litres per capita per day (Slum Shelter Environment _ Bhaskar Rao).

In slum areas however, these norms are not being met. One study puts the availability of protected water in Bangalore at 16-23 litres per capita per day. (3). There is only one source of water for every 53 families (inclusive of taps, bore wells, open wells) whereas the norm set by the government is one source for about 30 families (4).

Protected water is a scarce commodity for the slum dwellers. The common sources of protected water in the slums are taps or bore wells. There are large number of families depending on one source of water in the slums. Often 100 families depending on 2-3 sources of water, and may involve long waits in queues to get one or two pots of drinking water. Sometimes they have to walk distances of 1 or 2 furlongs to a tap where water is available and struggle with defective hand pumps. Many times it necessitates negotiating through clashes that develop over the short supply of water. It is generally a woman's role procuring water and is a burden added to the already crowded schedule she has. It is not surprising that she often does not have the motivation to procure the additional water needed daily for bathing and washing of the family and their clothes.

The problem as experienced by the slum dwellers are of the following nature. There are inadequate number of taps in the area, water is not turned on into the area from the main pipes for adequate time, many families do not have sufficient storage containers, some of the borewells' water is not accepted for cooking due to salinity, periodically there is breakdown of the borewell pumps with many barriers to speedy and regular repairs. Some of the barriers experienced are :

1. Lethargy of the concerned authorities to act, after repeated petitioning.
2. Complications and confusions brought in through bureaucratic compartmentalisation of responsibilities in the various government departments.
3. Vested interests of some people in the slum to exploit the gullible over these dire issues.
4. Lack of concerted energy or will of the slum dwellers to solve problems.

People in the areas surveyed are aware of problems arising out of improper drinking water and poor personal hygiene namely diarrhoeal diseases, skin problems and parasitic infestations and outbreak of epidemic during certain season. In the midst of problems they experience, the people react that it is impractical to think of personal hygiene as advocated by us (NGOs and Governmental health departments)

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(3) Report of working group on Urban Poverty 2.5.1
(4) Oral Communication, Study by S.S. Yarnol

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Inadequate facilities for Sanitation and Toilet

Sanitation involves mechanism for removal of solid wastes and liquid wastes (including human wastes) from the households in a regular and hygienic manner. So this requires adequate infrastructure of drains, rubbish dumps and latrnies, arrangements for closed types of drain which are hygienic and provisions for their regular maintenances and clearing.

Certain minimum norms evolved by government are :

a. 1 tap for 20 families;
b. 1 handpump for 30 families;
c. Street lights on all major roads at 30 metres interval;
d. paved footpaths
(Karnataka State of Environment report, 4.2 (1)

KSCB claims they provide basic amenities which includes drinking water, street lights, bath rooms, sewers, drains, roads etc., on an expenditure norm of Rs. 250.00 per head of the slum population under its jurisdiction Accordingly it is reported that basic amenities have been provided to 54 slums at a cost of Rs. 80 lakhs by 1983 in Bangalore (Reference No. 5). This works out to about a fifth of the slum population. The Bangalore City Corporation appears to have a more efficient system of providing and maintaining basic amenities in the slums coming under them. Corporation has appointed a staff person (Pourakarmika) for every 500 population for the maintenance of the basic amenities. Their work includes keeping the drains clean, removing solid rubbish from the foot paths and pavement and keeping public toilets clean. Further clearing of rubbish from the bins is done by Lorry teams. Whereas the KSCB's resources for maintenance appears to be very limited.

According to a study done in some slums in 1989-90 (Reference No 6) only 24% of hutments have smoke vent, 43% had no drainage connection to the public drain. Only for every 53 families was there a source of water (including taps, borewells and draw wells). Only 25% of households had private toilet. None of the public toilets had water supply.

In my experience in congested slums in the city core often space separating houses (foot paths) and rubbish dumps are cluttered with refuse and excreta that have been stagnating there. There is no rule followed as to where refuse is not to be put, or who should keep clean the spaces separating houses. Often refuse from one line of households is dumped near another line of houses. The dust bins are overflowing and not cleared at regular intervals. The open drains collect dirty household water and is sometimes used for open defaecation. It is worse in the rainy season when the blocked drains overflow sometimes even into the houses. Hence it is a source for outbreaks of diarrhoeal diseases, typhoid, cholera and hepatitis. In those slums where more planned drains have been constructed, the

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Ref 5. Karnataka State of Environment Report, 4.3
Ref 6. Oral communication Dr. S.S.Yarnal on the study of availability and utilization of basic services in selected slums of Bangalore.

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L-shaped small drains by the side of each household is the responsibili of the householder to keep it clean, while the U-shaped collecting drain is the department's responsibility to keep clean. In those slums which don't belong to the categories eligible for infrastructure, no drainage or waste removal system exists. As the maintenance and the clearing of the drains or waste removal is not regular, the wastes stagnate and are breeding grounds for infectious germs and pests.

Though slum dwellers recognise the hazards of the situation, they feel overwhelmed by their inability to do anything about it. Repeated petitioning to concerned office results in a half hearted response /th with no follow up. There appears to be no efficient system of maintenance of sanitation facilities, accountable to the slum community.

In slums generally use of toilets is non-existing. In the recognised and notified slums where some toilet infrastructure has been provided they are however not usable. The reasons are :

- The structure is often defective and not providing privacy, the removable parts doors etc., having been stolen;
- No water facility is attached hence they become intolerably dirty;
- people are not trained to use them, children are not instructed how to use them, hence defaecation is done indiscriminately around the toilet.

The corporation has experimented with the 'Sulabh Souchalayas' with not very good results. In public places they are functioning well. However, in the slums it is unrealistic to expect people to pay every time of usage. The officials are thinking of trying out a minimal toll monthly per family.

This situation is reflected in the disease trends in the slums. There is high incidence of water borne diseases like diarrhoeas, dysentries, worm infestations especially hook worm infestation with anaemia. Slums are endemic areas for certain diseases like typhoid, cholera, hepatitis, which periodically breaks out of the confines of the slums as epidemics.

Suggestions

As has been noted earlier

1. the provisions for basic amenities is not adequate. The government' minimum norms for the slum areas have not been met. The allocation for maintenance activities has not been either adequate or is not being implemented properly. A comprehensive strategy is to be worked out for providing basic amenities, including strengthening the organisation in terms of personnel with requisite skills.

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2. The bureaucracy and lack of responsiveness and callousness of the various involved government agencies results in long delays in repairs and maintenance. Information needs to be made available to slum dwellers regarding where to go for what help.

3. The community should be involved in the planning of the programme so that creative solutions could be looked at. As an example much experimentation hasbeen done throughout the country in the area of toilets, regarding what will be most workable for a particular community - community toilets, group toilets or individual toilets.

4. Active dialogue and education process should be done with the community both for creating the need and motivation for usage of toilet and sanitation measures as well as for encouraging responsibility taking in their maintenance. Most of rural India does not have toilet or sanitation facilities. Hence usage of these is not present in the cultural traditions of rural migrants. Therefore education about the health hazards resulting from improper usage and training in proper usage need to be done. In the same manner maintenance of the facilities is not possible without the community's involvement. NGO groups play an important role in these areas.

Inadequate shelter

Housing

In majority of the Bangalore slums shelter is a dire need. Both the structure of hut and the environment in which it is situated are unsanitary. The hut walls and roof are usually katcha made up of mud, thatching of waste materials. The environment is often low lying liable to be flooded or situated in polluted areas or densely populated. The approach to the hut is often water logged and damp from not being paved. There is generally no physical amenities available or provided. It is estimated that 50% of the slum dwellers clean themselves in the outdoors. Toilet facilities in large number of slums are non existent.

There are a host of problems in the way of the slum dwellers preventing him from procuring proper housing. Biggest problem is due to lack of tenurial rights (patta). It takes prolonged process of over a decade with several notifications to go through before slum dweller becomes eligible for patta. The next problem is the lack of funds available to the slum dwellers for cost of construction of the hut or for obtaining basic amenities.

Recognising the great shortage in housing in the country and the steadily increasing backlog. The Draft National Housing Policy recently formed aims at reducing housing shortage substantially

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by 2000 A.D. and will facilitate :

1. financing of house construction
2. land development in urban areas
3. development and application of low cost technology in house construction.

For Bangalore slums KSCB and BDA have been the main agencies dealing with housing (Chapter IV, Table 5) the goals of the board include :

- To undertake environmental improvement, clearance and redevelopment of slums;
- To construct tenament for slum dwellers from loan assistance from external agencies;
- To protect bonafide slum dwellers from eviction by landlords.

In a survey in 1981 it was estimated that the shortage of housing for slums in Bangalore was 60,000 units (Reference No. 7). KSCB with assistance from HUDCO (upto 80% of the cost of the unit) has been constructing houses, so far 1,757 units have been constructed costs ranging from Rs. 9,000.00 to Rs. 18,000.00 per unit (Reference No. 8) (upto 1983-84 the ceiling on each house was Rs. 8,000.00 and after 1984-85 the ceiling has been raised by the government to Rs.20,000.00) Bangalore City Corporation constructed 194 units during 1985-86 and subsequently has had negligible contribution.

Limited though the construction activity has been from government side it has not been effective in meeting the housing need. A recent survey of HUDCO financed houses showed that 73% of the houses, constructed for Economically Weaker Section (E.W.S.) were occupied by low-income groups (Iyer, 1982) Majority of slum dwellers were unwilling to be relocated, but 50% were willing to move into multi storeyed tenaments in the locality (Reference No. 9). This is related to the need to be near to place of work. Another difficulty has been that the quality and design of the construction has been poor. Their design for hutments does not take into account, the needs of the particular slum dweller or their community dynamics. Quality of construction suffered from high level of corruption involved. In the context of the magnitude of the housing shortage and the paucity of funds available, a better option appears to be the 'sites and services scheme'. Giving the slum dweller tenurial rights and providing basic amenities and assisting him/her to get loans for tenament construction seem more practical. Here it is relevant to look at an NGO experience.

I will briefly describe the process that an NGO group, AVAS (Bangalore) and two communities, slums of Lakshmipura and Someshwara (near Ulsoor) went through in the process of obtaining reasonable housing in

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Ref No. 7 Slums - Shelter, Environment improvement programme - Bangalo: Hubli, Dharwar - Prof Bhaskar Rao, July89

Ref No. 8 ibid

Ref No. 9 ibid

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Bangalore. The initial stimulus for the communities was threat of eviction. The situation of their housing at the start was very poor with regard to the structure of the hut, the environment and the amenities. There was initially prolonged discussion with the community to clarify their need. This needed to be viewed in the context of the thickly populated and of high land value situation. Some initial provision of infrastructure in the form of paving of footpaths, covering of drains, were made. Various options for the land layout and design of the structure were looked at. Since land was tightly packed a double storey structure was found to be optimal. Affordability was looked at in detail. Information on various government programmes and subsidies were made available. In the process of the prolonged discussion many changes in design were made. For eg., from common bath room toilet to individual toilet and individual bath-room cum front area.

Negotiations between the corporation authorities and the community were conducted with the NGO playing an intermediary role towards eliciting corporation's active participation and for lowering of the civic norms. A special committee of the corporation was set up with representation from the NGO group and the slum community. Some of the norms were relaxed for e.g., minimum area per dwelling was changed from 200 sq. ft. to 80 sq. ft. A committee of the slum community was set up to take responsibility for construction. People were involved in the construction by contributing labour and subsidised costs. When sections were demolished for starting construction the motivated community arranged for transit accommodation. However, there were long delays in the project, the corporation took a long time to approve plans and changes. Because there were some officials who had been exposed to such ideas in the past eventually approval was given. Further delays ensued from divisions in the community resulting in stay orders. Continued facilitation and discussions with the community helped them to come together constructively. Funding was obtained 80% from HUDCO and 20% from the corporation to be paid back by the slum dwellers in small instalments of Rs.100 per month. Assistance for purchasing of certain items through loan purchase was provided.

By the end of the project, the initial estimates were over spent by about 30% more. The community is negotiating with the corporation to pay the inflated amount. It was seen that the back bone of the whole process were the women of the community. It was their persistance that cleared out difficulties.

Looking at the gigantic outlay of capital required to provide housing for everybody, the practical approach may be through 'sites and services'. Provide tenurial rights to the slum dweller, provide basic infrastructure of roads, water and sanitation and support through loans for individual's construction of housing.

B. <u>Social Factors</u>

We have seen that physical factors contribute considerably to the ill health of the slum dwellers. Social factors also contribute to a variety of ailments and lowered levels of health. These factors play their role in two-fold ways - by affecting the

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mind produce many psychosomatic and psycho social illness e.g., gastric ulcers, depressions, alcoholism. They keep people ignorant and oppressed and block their power to change disease producing factors. The struggle for protected water and sanitation amenities is spearheaded by the women slum dwellers, and often the first people to discourage them are their menfolk. Hence I see the following social factors as significantly contributing to ill health.

1. Women's oppressed situation
2. Dynamics of the slum community and the poor leadership
3. Psycho social problems such as alcoholism.

Women's oppressed situation

Women have a lower status than men in the slum communities and there is clear role differentiation to theadvantage of the male. Cooking, bringing water, domestic chores, looking after the health of herself and children are seen as women's role. As men are the primary bread earners, they decide and spend more than 50% on their individual expenses. It is not uncommon for men to have more than one wife or abandon their wife and family to fend for themselves. There is high incidence of domestic violence on women and large number of suicides among women (suicides data are not available). Very few women are to be seen among the traditional leadership of slums. Burdened as they are with the various demands of life women generally do not have opportunity to unburden their emotional tensions. In my experience women commonly suffer from anaemia, malnutrition, menstrual abnormalities and vaginal discharges. They also commonly suffer from back aches, depression and anxieties. In addition they are prone to other illnesses thatare prevalent in slum communities as outlined in the earlier sections.

There are many government programmes with women as the main focus. Under Department of Health and Family Welfare there are programmes for MCH, family planning and immunization. Under Department of Women and Child Welfare there is supplementary nutrition, women's organisation, income generation programmes, widow pension schemes, maternity benefits. The extension staff from these two departments are supposed to work among the slum women. In effect the Health and Family Welfare Department work concentrates mostly on family planning and perhaps more recently immunization is also given attention. It must be pointed out that the family planning programmes targets women exclusively. Slum women are not offered an informed choice but emphasis is on sterilization alone. The staff of the Department of Women and Child Welfare is too few in number and their training needs to improve to work effectively with slum women.

The attitude of allopathic system and its practitioners towards women's ailments generally reflect the status of women. Many of women's ailments and symptoms are traditionally perceived as being psychosomatic and hence they assume nothing effective can be done. However,

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not much effort and energy has gone into studying this area. It is my experience that majority of women who have undergone sterilization relate their present ill health to the tubectomy done several years ago. It is not clear how much is due to her situation which ultimately targetted her for this surgery.

NGO groups working in the slums prefer to work through women in the area of health as greater reponsiveness comes from them. They also stress the need for greater recognition of women's contribution in the informal sector. There is need for government to assure respectable minimum wages and maternity benefits to women working as domestic help. Women's groups seek that 'pattas' are granted in the joint name of both husband and wife rather than just husband as head of the family. They also highlight social issues which oppress women such as alchoholism and the state support to it, dowry violence etc. Female literacy is an area recognised as playing an important role in the health of the family.

Poor community leadership and community dynamics

Local exploitative groups and lack of responsible leadership :

Leadership as exists in slums generally is a block to the community's progress. They stand in the way of the community coming together, voicing effectively their needs and accessing and utilizing government facilities. There is generally no process for election or selection of leaders except where some NGO groups have facilitated this. Those who claim to be the leaders belong to the vocal group consisting roughly of 2-5% of the slum population, whose main claim to leadership resulting from superior occupation is their image. They generally do not have leadership skills or understanding of the needs and dynamics of the community, but would be motivated by selfish monetary goals. Hence any contact with the government establishment is a source of income for them and they have a vested interest in maintaining the exploitative situation.

In the three areas contacted by me, in one area the leadership was negative and blocking of development of awareness building, in another area supportive in principle but ineffectual in practice and in the third area no traditional leadership existed. In the last area women activists associated to an NGO group was playing this role in effect, the traditional leaders having been discredited in this process. Where there was supportive but ineffectual leadership, the leadership was based on the image of a few persons related to their superior occupations but who did not have much skills or understanding of the community needs. The exploitative leadership is often in collusion with local authorities and may be involved in illegal activities. Political parties cultivate them as easy vote banks with favours and immunity.

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They affect the health of the community by

a. blocking of building of awareness

b. blocking of health promotive action by the community

c. by contributing to the people's feeling of being ineffective to change factors affecting their health.

Concerned government departments do not recognise the need for healthy leadership nor promote activities leading to that, as they do not have any community organizing activity, except the minimal involvement through the Anganwadi workers.

Poor Community Dynamics

There is a lack of cohesiveness among slum dwellers, presenting as lack of initiative, inertia and division. It is difficult for people to get interested in issues other than their pressing concerns even though they demonstrate qualitiesof generosity and empathy. Kinship ties are present strongly and language and religious identification exists.

One would attempt to explain this on the basis of :

a. Lack of roots of the people and the fact that people from various cultural backgrounds are intermixed.
b. Individualism and materialism is strong value experienced in urban life and reinforced by media.
c. Ineffectiveness of their lives in the face of the forces of urban life, combined with the handicap of being illiterate and perhaps a migrant.
d. Internalisation of the 'marginalisation' of their lives, resulting in a poor self image. The rest of the society looks on them as dirty, drunken and made up of thieves.

In my opinion apart from their needs for physical and social amenities, they have the need for building a self respecting ego.

As mentioned earlier there are few governmental activities directed at building up the community.

Psycho social problems like alcoholism

Alcoholism and excessive consumption of alcohol :

Excessive consumption of alcohol appears to be a common problem in the slums of Bangalore. The women slum dwellers consider it as a major concern as this problem affects their lives in a harsh way (10) The impression gained from them is that the majority of their menfolk consume alcohol regularly or whenever they have money in their hands. Though only a minority perhaps 25% are alcoholics (dependent on alcohol) the rest are affected adversely from the financial strain.

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(10) Discussions with women slum dwellers

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In those families where men are alcoholics, often the women are force to become bread winners and the men harass the families. Much damage is evident in the form of malnourished and uncared for children, regular domestic violence and broken family life. The majority of menfolk though not alcoholics consume alcohol often. The stated reasons for this situation are that :

1. Due to the heavy physical work they indulge in, alcohol helps to relax mind and body.
2. They feel low self esteem as a result of them being marginalised from society for being poor. Alcohol promises to improve self esteem.
3. It is also a cultural value for men to drink to demonstrate man-hood.

As a result of this behaviour and tradition the meagre family income is further depleted. The productivity of the individual comes down as several days of work are missed, following bouts of alcohol. There is neglect of the family perhaps harrasment of the family and domestic violence. Ultimately in an addict, physical health is damaged irreparably due to the effects of alcohol. Worse still for the community it is the weakening of the community's ability to come together for responsible community action.

The Government's policy in this matter appears to be in the direction of increasing the production of liquor and increasing the licenses of liquor selling shops. This is a major source of revenue for the government. Large number of illegal arrack shops come up in or near slum areas with the tacit connivance of the authorities. Slum women's groups have highlighted this issue before the authorities, even at the ministerial level. There have been no concrete response except in the form of assurances.

The non-governmental sector also does not have much to offer in this matter. Even for middle income groups adequate facilities for counselling, detoxification or peer group support, do not exist. Hardly any inputs exist for slum dwellers. There are case studies from other areas where community action to combat alcoholism was carried out successfully by groups especially organised women. In carried out successfully by groups especially organised women. In Bangalore slums, I studied, I did not come across such actions, nor am I aware of such actions in Bangalore slums.

Poor Health Education

Health Knowledge and Awareness :

Health knowledge and awareness plays an important role in the health status of a community. If ill health results from the interplay of factors that negatively affect the body and mind of the individual, namely the physical environment around him and the social environment

around him, then the first step in putting it right is an understanding about it. Understanding and awareness could give the strength to individuals and communities to take control of these steps towards correcting them. It is to be noted that there is no state of perfect health but, the process of moving in that direction raises the standards of health.

Not many studies regarding the knowledge, attitude and practices of slum dwellers of Bangalore regarding factors that affect health were available to me. According to one study in some slums illiteracy was 47% with 40% of males and 54% of females being illiterate. Only 12% of mothers knew that tetanus toxoid injections would protect mother and child. Only 52% of illiterate mothers know schedule of immunization. Only 27% of illiterate mothers initiated breast feeding within 12 hours of delivery as against 42% of literate mothers. Only 30% illiterate mothers adopted one or other method of family planning as against 81% of literate mothers. (S.S.Yarnal - 11)

In my experience health knowledge and awareness among slum dwellers is very poor. There are existing beliefs about causation of diseases and the responses to it. Many of the beliefs are based on religious ideas with goddesses being attributed as the source of illness and certain dietary and other rituals being necessary to propitiate them. Beliefs about food items as being 'hot' or 'cold' and their effect on the health of the body abound. The relevancy of the beliefs for the community health worker is two fold. If the beliefs don't permit the person to take charge of the factors affecting his health they become a block. Being aware that each one is operating out of one's own belief system and nobody has perfect knowledge it becomes important for the health worker how he/she reacts to some of the beliefs and practices which are outside of one's experiences. Health education has been rightly given high priority among governmental health extension work and by the NGOs who work in the slums.

Health education efforts of the government staff tends to have a formal routine approach and hence tends not to have much impact. At their best they try to communicate simplified health messages through media like posters, charts, video programmes or by demonstration. The topics mainly are confined to health service priorities like MCH, Family Planning, Immunization, Nutrition, of children and mother, communicable diseases. It is observed that education of illiterate people in this manner is a slow repetitive process and behaviour change in a particular area may take one or two years. The functionaries who are involved in this task are the extension staff of urban Family Welfare Centres (UFWC) and the Primary Health Centres (PHCs) situated around periphery of the city.

Non-Governmental Organisations (NGOs) have the freedom to innovate. They use traditional cultural media like puppetry, folk songs, dances and street theatre. The subjects chosen for education are more closely identified by the community eg., issues like rational use of drugs, inadequate health services, women's situations etc.

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Certain activists are able to tap the motivation and energy of people for learning. They believe that all learning is experiential. They allow the community to verbalise their pressing needs, and facilitate community action to meet these needs. People learn from the reality situation they encounter. They learn to develop confidence in their ability to change disease producing situations and macro forces and in this process develop a value system that is helpful in meeting everybodys' needs.

In my opinion there are several levels at which slum dwellers need to learn

1. Information regarding the interplay of disease producing factors and evolution of disease. e.g.., water borne diseases - how disease results from unprotected drinking water.
2. Learning to give significance and priority to disease producing factors in the face of pre-occupations with other pressing needs.
3. Learning to believe that these factors can be changed.
4. Learning to believe in themselves as agents who can change these factors.

Health educators who recognise these levels of learning and provide the learning environment for this are likely to have an impact on the health awareness of slum dwellers.

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C H A P T E R VI

Health Care Facilities in Bangalore

Bangalore has organised health care services provided by a network of hospitals, Nursing homes, maternity homes, health centres, dispensaries and health extension programmes. But these facilities are mostly not available to the slum dwellers because of their high cost elitist character or because of the biased , profit oriented motive of the practitioners or because the model is not suited to respond to their particular needs. Outreach services form only a small portion of this network and are inadequate to provide the primary health care needs of the slum dwellers. This network is made up of government, voluntary and private sector.

A. Government sector:

Under this heading are included facilities at the primary health care level, secondary level of referral and at the tertiary level of large speciality hospitals.

B. Voluntary sector:

This consists of NGOs (Non-Governmental Organisations) involved in providing primary health care to the poor and larger mission hospitals associated with religious groups mainly offering secondary level of care and having limited extension services.

C. Private sector:

This consists of a very large number of private practitioners (General Practitioners) and the nursing homes and 5 star hospitals.

In this paper I will be giving more emphasis to the facilities available to slum dwellers .

A. Government Sector

Health care facilities for the slum dwellers of Bangalore are provided mostly by the corporation health department with some contributions at the periphery of the city from the PHCs of the peripheral region. As mentioned earlier neither KSCB nor BDA participates in health.

For sake of clarity the corporation's health care facilities can be looked at under the following headings :

i) Facilities specifically for the slum dwellers
ii) Facilities which can be availed of by the slum dwellers.
iii) Referral institutions

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i) Facilities specifically for the slum dwellers

a. Mobile Dispensary

There are three mobile dispensaries with one mobile dispensary planned for the area coming under four administrative ranges of the Corporation. It is staffed as follows:

Medical Officer	1
Staff Nurse	1
ANM	1
Ayah	1
Driver	1

Roughly 20 slums are covered by each mobile dispensary, on a once a week basis. Service provided are out-patient diagnosis, treatment and referrals free of charge.

In addition this team takes up mass epidemic immunization in conjunction with sub-health office.

In practice the team visits 2 or 3 slums in that locality everyday. About 30 to 40 people from each slum avail of the facility. Symptomatic treatment is given. The referral system is not worked out adequately and those needing referrals are orally told to go to the particular centre, more often without any document. This is contrary to what the concerned doctor said in relation to the referral systems. There did not appear to be any community contact, build up, in fact the activity is carried out without the team having to get down from the Van.

According to the medical officer adequate drugs are available.

It is my impression that the mobile health team does not develop much understanding of the dynamics of the slum and the disease producing factors nor a sense of involvement, as it would require an orientation experience and guidance. There does not appear to be co-ordination meetings of all health staff of corporation involved in the slum area

b. I.C.D.S - Anganwadis

There are two ICDS projects functioning in the city of Bangalore, together having about 200 centres and covering about 2 lakhs population. Anganwadis are primarily serving slums and economically backward SC/ST areas. About 15,500 children are enrolled and the activities are the following

Health

- Treatment of common ailments
- Growth monitoring
- Quarterly medical check up
- Nutrition supplementation immunization

Education

- Literacy and numeracy for 3-6 years old
- Mother's meetings
- House visiting
- Record Keeping

The nutrition supplementation is given in detail in the section on malnutrition.

This programme appears to be functioning effectively among the population covered though it is covering only about 50% of the slum dwellers. The Anganwadi teachers are not very skilled at community organisation through the women's meetings, but appear to be skilled with the children. There is good co-ordination produced with the corporation UFWCs. The other concerned departments of the government like Slum Clearance Board or Bangalore Development Authority are not involved. The programme has not been able to achieve much participation from the slum dwellers in supporting its day to day running.

c. Milk Centres

In addition to the ICDS centres there are 11 milk centres run by the corporation to supplying milk and bread. These have not been integrated with the ICDS programme and are vestiges from the previously existing nutrition supplementation programmes of corporation.

ii) Facilities which can be availed of by the slum dwellers

There are other corporation health structures which are available for the public at large though intended more for the economically backward.

a. Urban Family Welfare Centres (UFWC)

There are 37 UFWCs functioning out of which 19 are directly run by the corporation health department and the rest with assistance from voluntary bodies, medical colleges and others. The coverage of one UFWC is roughly 50,000 population. By that criteria only little over half the population of Bangalore city is covered. Slums coming in the geographical area of these centres are covered by them.

The usual staffing is

Medical Officer	1
Lady Health visitor	1
ANMs	2
Ayah	1

Their activities are primarily extension work and include the following

- Survey of all the households
- House to house visit to cover all households in a month
- Ante-natal and post-natal care domiciliary
- Health education
- Conducting immunization camps to ensure universal coverage
- Family planning motivation
- Record Keeping

Each ANM is expected to cover 15,000 population and L.H.V in addition to her supervisory function covers 5,000 population.

Their activity is focused because of the targets expected on family planning and immunization programmes. They do not have any special orientation or training on aspects of urban slums to facilitate their functioning. It seems to me that a population of 15,000 - 3000 families is too large for 1 ANM to cover effectively, compounded by the fact that during their hours of work slum dwellers are not available. It is my impression that the extension work is irregular and not very effective and not much rapport is established with the slum dwellers. The health education work is negligible.

b. Maternity Homes

There are 29 maternity homes.

The staffing is as follows :

Medical Officer	1
Staff Nurse	1
ANMs	3
Ayah	3
Peons	3
Pourakarmikas	3

The functions carried out are ante-natal care, delivery care except caesarian, post-natal care, family planning service.

Their area of coverage is not demarcated, and they do not have any out reach programmes. It is my impression from the slum dwellers that they experience several blocks in utilizing these facilities, which will be elaroborated later under the heading 'Access to health facilities'.

c. There are 14 corporation dispensaries which includes 1 Ayurvedic dispensary and 1 Unani dispensary and 25 local fund dispensaries aided, by corporation and 12 sub-health offices coming under corporation Range Medical Officers. The usual staffing patterns is

Doctor	1
Compaunder	1
Peon	1 or 2

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Functions carried out

- Outpatient care (free of charge)
- Outpatient immunization
- Record Keeping

These dispensaries were not actively planned for but, are historical relics. They don't have an area demarcated for which population they serve, the records maintained are poorly designed and convey very little information. For example, it is not possible to identify the patients coming from the slums from the records. There is no outreach programme.

d. There are 22 primary health units functioning in the peripheral regions of Bangalore city.

They are staffed by

Health worker - female	1
Health worker - male	1
Ayah	1

Their activities are according to the PHC programme and include extension work.

- House visiting and health education
- Immunization coverage
- MCH ante-natal, natal and post-natal services
- School Health
- F.P. Programmes
- Keeping records and registers
- National programmes

The slums that are located in the periphery of the city are provided with some care through these centres.

ii) Referral Institutions

a. Government Referral

There are many specialised referral hospitals functioning in this city both under the State government eg., Victoria, Bowring and some under Central government like the Central government factory hospitals. There are some institutions that are autonomous bodies e.g., Kidwai oncology centre.

However, these referral hospitals are often not accessible to the slum dwellers the reasons for which are discussed in the following pages. The referral hospitals are tuned to serve the richer and more influential members of the society. More attention goes to pay wards and speciality departments. The factor of private practice of the professionals formalise this emphasis. The periodic disclosures of malpractice in the hospitals are common now in the country.

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b. Accessibility of health care services of the Government sector

In general government referral services are inaccessible to the slum dwellers, nor do they get quality care from the corporation maternity homes and dispensaries. A slum dweller woman faced with a critical disease of her child or herself borrowing 10 or 20 rupees and with an empty stomach seeking medical assistance from the government hospitals meets with many problems in obtaining good care.

Being illiterate she has difficulty finding the right hospital, and the right room in the hospital. She feels intimidated by the strange situation and the hostile attitudes of the staff. A language barrier may add to the problem. There is long wait in queues and usually a day is spent in a visit and sometimes, she may have to go back without meeting the doctor with a facile instruction from the attender that the unit does not work that day. When the doctor does see her, it could be an abrupt tense interaction with no effort made to explain the illness or the treatment. Often, busy doctors are irritated and abrupt with people they perceive as talking round and round or not comprehending. As treatment she may be given a symptomatic remedy and a prescription of antibiotics and tonics to be bought elsewhere. She of course does not have enough money and so will buy only partial doses or some of the non-essential items, usually tonics. If the illness requires further investigation or admission, she has to pay at many steps along the way as corruption is common in the government set up. If follow up visit is required, it is unlikely she will return as the cost of transportation charges, loss of wages and medical expenses and the disruption in the domestic routine put together is beyond her capacity.

The doctors by their training are not sensitive to the causative factors of the diseases of the poor or about their situation and their treatment is often wrongly directed at superficial symptoms. The essential medicines that may be required are not made available. There is a class and cultural gap between the doctors and the poor demonstrated in the form of biased attitudes, impatience with the poor so that without the necessary explanation they are dismissed, and lack of empathy with their suffering. There are recorded incidents of government doctors taking advantage of the ignorance of the poor women, to insert family planning devices without their informed consent.

Many of the nursing staff trained in the same mould carry similar values. It is accepted experience in the government maternity homes to be treated in a humiliating way, to have to pay to know the sex of the new born baby or to have to pay to get the bed pan. The little health education given is often in the form of being talked down to and hence not accepted.

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The common attitude of the poor in the slums is that they cannot get good health care from the government centres. Even in the many instances where adequate health care was given, they do not have belief in the system.

Hence the areas to be addressed include an appropriate model of health infra-structure being adopted, adequate resources being allocated, the community being included in the planning and execution in the form of grass root workers who are given credibility by the institution. Also to be addressed is the development of mechanism for answerability to the poor so that professionals develop the right attitudes and respon-bility.

B. Voluntary Sector

This sector includes

i) Non-Governmental Organisations (NGOs)

NGOs who are involved in primary health care work with slum dwellers more often having multi-sectoral involvement with the slum dwellers. In Bangalore there are a large number of NGOS functioning almost all obtaining their support from foreign contributions.

ii) Mission Hospitals

There are also the mission hospitals belonging to the various religious groups. They are primarily secondary level hosp-itals who offer some care to the slum dwellers and may also have extension services for the slum dwellers.

Non-Governmental Organisations (NGOs)

NGOs working in urban slums generally have a multi-sectoral approac
Their components of work include :

- health worker network capable of discharging many functions like health education, treating or common ailments, usage of home remedies.
- Improving basic amenities either directly or by facilitating governmental programme.
- facilitating access and utlization of governmental health outreach programmes and referral facilities.
- Involved in skill trainings and income generation progra-mmes.
- Women's organisation and community organisation .
- Usage of low cost and simplified technology in health educa-tion, in monitoring of health programmes.
- Involvement with special problems e.g., the handicapped people.

The levels of understanding and functioning of the different groups vary. Many groups focus on health related activities

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like nutrition supplementation, treatment of minor ailments and periodic health check ups. Some others are focusing on health issues like appropriateness of health technology, rational drug treatment and pressurising government to recognise the basic needs of the slum dwellers. NGOs who initially start their involvement in the field of health subsequently discover the need for multi-sectoral involvement. Generally NGOs are accessible to slum dwellers and have good rapport with them through their facilitation the participation of the community in the government programmes also increase.

There is not much coordination between NGO groups, nor effective joining hands for pressurising government on 'issues'. There is a certain amount of suspiciousness among the NGOs regarding the intent of the other group, and a belief that one's own approach and methodology is the right one.

There is also the recent phenomena of mushrooming of NGOs with any unemployed person metamorphosing into an NGO once they have figured out how to operate the'funding channels'.

Under the chapter heading 'background' I have summarised the health related activities of one NGO group - 'Women's Voice' I was involved with this group for four years. They started as a group that wanted to raise the issue of slum women. In this process the slum community expressed to them their urgent need for health care. Community participation was offered in the form of volunteers who came forward and space was offered for conducting meetings. We began tentatively by addressing the need for treatment of common ailments and moved on to training of the volunteers as health workers,, facilitating preventive and promotive programmes of the government health department, health education, self-help activities regarding environmental hygiene. The roles of the health workers gradually transformed into organizers for small income generation schemes, contacts for availing of government programmes and leaders for demanding basic amenities of the government. In this manner community's health care needs were being addressed at different levels. Further details of the programme can be read in the background chapter.

Mission Hospitals

Mission Hospitals

Many of the mission hospitals in Bangalore have a charitable approach. They have some provision for concessional treatment for the poor and also some outreach programmes in the slums. The private medical college hospitals also come in this category as some of them have assumed geographical responsibility for health care in a few of the slums. They are a good resource for the care of complicated health problems of the poor. However, the facility is available only in limited numbers

C. Private Sector

The health services provided by the private sector, for our purposes can be grouped under:

i. Services provided by private practitioners,
ii. Services of Nursing homes and large hospitals run by corporations.

In the slums of Bangalore the services of private practitioners are quite significant while those of the second category are insignificant. Hence I will not be describing the activities of Nursing homes and private hospitals.

i. Services provided by private practitioners

There are a large number of General Practitioners (GPs) practicing in the city and many of them have their practices in and around slum areas. A survey (reported by Dr. AS. Mohammed of Community Health Department of St. John's Medical College) claims that 85% of slum population avails the services of GPs. Some of the positive aspects of the service of the GPs are that they are available near to the slums and are available at the times that slum dwellers need their services (after work hours). They also provide consultation and medicines at an affordable cost for one visit about Rs. 10 on an average.

On the negative side it is my impression that there is much to be desired in the effectiveness of their work. In many instances, the treatment given by the GPs is irrational. The dosages are not for adequate number of days. There is excessive use of injections, drugs producing immediate but transient results are favoured, the prescriptions involve non-essential and costly items which may result in the slum dweller not procuring the essential items. The irrationalities in treatment many times result in worsening of the symptoms subsequently or it is argued of development of drug resistance to some of the essential antibiotics. Another area of neglect is that often no importsnce is given to health education so that the slum dweller remains ignorant of the causes of the disease and could repeatedly get back into the same diseased state. It is worth noting that there is great faith bestowed on 'injections' by the illiterate people as having some magical property of healing. The GP is forced by this belief of people to administer unnecessary injections and also it seems to benefit his practice.

In the prevailing situation a trained health worker in my opinion is able to provide more effective service. The health workers by and large provide rational care within the limited skills they possess. This is not to negate the genuine caring and service being put in by many conscientious GPs. The present reality as I understand is that there are a large

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number of underemployed medical practitioners desirous of settling down in urban areas, competition sometimes unethical exist in the search for 'practice', and there is unmet need of urban poor for primary health care. Some interventions as seen in the UCD (Urban Community Development) programmes of Hyderabad and Vijayawada could be useful. Many practitioners are provided part-time employment through UCDs' health programme where they provide primary health care and training to workers from the community. Under such a scheme some control to ensure rational therapeutics and accountability to the community could be aimed for.

C H A P T E R VII

Initiatives of the Government at the National and Regional Level

- An Overview

At the national level there has been no policy on urbanization process and problems of urban poor. The planners and leaders have contradictory and half hearted approach to this problem. At a philosophical level the approach has been decentralisation so as to make self-sufficient villages at the periphery. In practice, in terms of allocation of funds etc, the trend has been in favour of major metropolitan cities. Very little funds have gone to small and medium towns' development which was the favoured policy. The problems of urban poor have got little recognition until recently. Though in the III Five Year Plan few experimental urban community development (UCD) schemes were initiated, these were not followed up and promoted actively. In the 5th five year plan though recognition of the problems of urban poor was made, no separate provisions or programme were included. It was only in the 6th five year plan (1980-85) that definite action plans towards alleviating urban poverty started. Towardsthe end of 7th five year plan in 1986, the urban basic services was initiated in a phased manner. This was the first time a comprehensive plan for the specific upliftment of urban poor was made and funds allocated. In the following paragraphs aspects relevant to urban development from each of the five year plans are detailed, and few significant efforts from some of the States highligfited. It will be noted that though policies and acts favouring the urban poor were made and recommendations of similar nature made from the beginning of planning process, definite commitment in terms of allocation of funds has been made only from 6th plan period. Inspite of this funding the ability of government machinery to uplift the lives of the poor has yet to be proven.

The stress given in various Five Year Plans on urbanization and planning for urban poor

First Five Year Plan (1951-56)

Recommended Model Act for controlling land prices in metropolitan areas in the context of acute shortage of housing and rapidly rising land prices. No follow up action was taken on this.

Started following institutions and departments :

1. Ministry of Urban Affairs,
2. National Building Organisation for designing low cost housing,
3. School of Planning and Architecture and a Department of Town Planning.

Massive house construction and land development particularly in Delhi towards settlement of the refugees from Pakistan.

Slum Clearance Act passed for Union Territory of Delhi.

Second Five Year Plan (1956-61)

Recognised need for planned development of cities and towns and need for integrated approach to rural and urban planning, namely planning should be for a region. Not much follow up was done on this.

i) Town and Country Planning Organisation (TCPO) was set up in 1957.
ii) Delhi Development Authority (DDA) was set up to implement Delhi. Master Plan (This was a major step in initiating city planning and implementation in other states)

Slum clearance Act made.

Third Five Year Plan (1961-66)

Model State Town Planning Act prepared by TCPO which led to enactment of such laws in all states.

States established Town Planning departments recognising the urbanization problem.

Advocated development of policy which would locate new industries away from urban areas using industrial licensing as an instrument.

Initiated on an experimental basis Urban Community Development (UCD) schemes in 22 cities to solve social and human problems associated with urban slums. This was the first specific planning for the urban poor. Though in a very inadequate way, these however, did not get followed up or promoted actively.

Fourth Five Year Plan (1969-74)

Established HUDCO to finance schemes for housing in urban areas.

Plea made for enacting urban land policy at state level.

1972 - Introduced Environmental Improvement of Urban Slums (E.I.U.S) This was to be extended in a phased manner.

Fifth Five Year Plan (1974-79)

Detailed statement on urban problems and policies, recognising the problems of the urban poor. However, no separate provisions or programmes for urban poor was made, while lion's share of funds were allocated to development of metropolitan cities.

ICDS programme initiated.

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Sixth Five Year Plan (1980-85)

Special chapter on Urban problems and stressed identification and measurement of the poor.

Started many poverty alleviation pgoramme

(Integrated Rural Development Programme (IRDP), National Rural Employment Programme (NREP), Rural landless Employment Programme, Sites and Services Scheme, Economically Weaker Section Housing Programme (65,400 shelter units constructed in the public sector, though these were beyond the reach of most of the slum dwellers),.

The National Housing Bank set up with an equity capital of 100 crores.

Working group on reorganisation of Family Planning and Primary Health Care Services in Urban areas set up.

Integrated Development of Small and Medium Town (IDSMT) Programme started to set right special imbalances in urban development and attract migrants to smaller towns.

Seventh Five Year Plan (1985-90)

Draft National Housing Policy made which has a section on informal sector housing and slums. Some of the stipulation in this section are :

i. Stepping up programmes for environmental improvement of slums by providing basic amenities.

ii. Conferring tenurial rights at reasonable rates in respect of land occupied by slum dwellers wherever possible.

iii. Relocating slum dwellers to the extent possible where it is not possible to give tenurial rights.

iv. Making available land for sites and services for slum dwellers.

v. Providing easy access to institutional finance for upgrading or redevelopment of their dwelling limits.

And a host of other steps that would make it easier to improve the housing situation of slum dwellers.

National Commission on Urbanization set up to study and recommend plans and policies.

Urban basic services (UBS) started with UNICEF support merging Low cost sanitation and Small and Medium Town Planning Programmes.

UBS : This is a multi-dimensional and community oriented plan involving the integration of services of central government, the State government, local bodies and UNICEF. This plan hopes to promote citizens participation, strengthen the service capabilities of local bodies in working with people on community felt needs, bring about convergence of services and coordinate resources of various agencies. In this manner it is hoped to upgrade the

quality of life of urban poor especially the most vulnerable sector - women and children.

Seccessful initiatives from other Cities and States

The Community Development Wing of Tamil Nadu Slum Clearance Board runs a skill training programme for candidates from slums. About 5,000 people have been trained in various trades upto 1987, in selected institutions run by government or private trusts. The training expenses and stipends are borne by the government. About 60% of the trainees find employment or are self employed.

West Bengal

Calcutta Metropolitan Development Authority set up 'Small Scale Entrepreneurs Programme (SSEP) to support economic activities of slum dwellers benefitting 3,911 beneficiaries with a loan disbursement of Rs. 91 lakhs.

Andhra Pradesh

In 1987 in Hyderabad a slum community development project was started following the success of similar project in Delhi supported by Ford Foundation. The project has the following components :

i. Grant of legal title (Patta) to the slum dwellers in the land that they are occupying.

ii. Assistance in laying out and constructing self help low cost housing.

iii. Assistance for increasing access to organised financial sector.

The project sought to encourage the slum dwellers to make this as their own project rather than a government intervention, provided a facilitator (Basti Sahayak) in each slum area. Subsequently it expanded to the whole city and developed a multisectoral approach to provide civic infrastructure, housing, health, pre-school education and economic support programme.

As can be noted from the above very little concrete planning or allocation of resources specifically for the urban poor has been done during the earlier part of our planning process. What had been done was in a patchy compartmentalised way. The clearest thinking and commitment of the government towards the urban poor is contained in the UBS plan. This plan has many strengths included among them are the conscious attempt for community participation and involvement of NGOs. According to me, an important weakness of the plan is that it does not consciously recognise and plan to tackle the underlying factors of the urbanization process, but attempts to alleviate the miseries of the urban poor.

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Conclusion

The problems of urbanization and urban poor result from factors affecting both at the macro level namely national level and at micro level namely at the level of the city or town. At the macro level the socio economic development plans adopted by our country has led to increasing pauperization of the rural poor and their displacement by various forces. The concentration of capital and resources in the urban areas in the form of industries, development of service sector and the large scale housing construction has increased unskilled low paid job opportunities for the poor. Coupled with this process, there has been inadequate recognition, planning for and allocation of resources for the urban poor by the government, nor a balanced development of urban agglomerations of regions.

At the micro level also several factors play a vital role in the crisis of urban planning and slumming process and the miserable living situation of the poor. There is greater migration to metropolitan cities which have three types of activities namely industrial, commercial and service. The high cost of urban land has taken it beyond the purchasing capacity of poor, while local governments have not implemented protection of urban land policies. The local governments have followed the national pattern of ignoring the needs of the urban poor. There has been neglectful and inadequate planning and allocation for meeting the needs of the urban poor of basic amenities of social services and of minimum wages. The politicians have exploited the captive population of urban poor and promoted destructive and violent dynamics.

Karnataka and Bangalore have been examples of the above factors. Hence the problems of the poor of Bangalore are not different. In the succeeding paragraphs, I would like to summarize my ideas arising out of my limited experiences with the slum dwellers in a few slums of Bangalore.

It appears that the problem of numbers of slum dwellers in Bangalore is smaller as compared to comparable metropolises in India. Hence the problem to be addressed is a shade easier, if determined effort and political will is present. The government establishments concerned with slums appear to view the problem of slum dwellers in a narrow and rigid way. Hence the planning for slum dwellers reflects a compartmentalised inadequate and unimaginative approach and could benefit from more interest and involvement. They also need to develop a holistic understanding and attitude.

The records kept regarding various aspects of slum dwellers are totally inadequate and hence is bound to produce inferior planning. There is no provision for regular contact with slum communities or for facilitating the development of the community. Hence maintenance

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of infrastructural facilities and liaison and feed back from the communities are adversely affected and at the moment are very negative. It does not appear that all funds that can be tapped are getting tapped. The recognised slums have certain amount of physical infrastructure. But, those under notification or are presently unrecognised are grossly lacking in physical infrastructure and are subject to various environmental danger.

The provision of social services, (Health, education, cultural) are scanty and not coordinated and hence a large number of slum dwellers find themselves without access to even essential health services, compounding this fact is the callous or sometimes hostile attitude of health officials especially in the specialised referral institutions. One did experience a certain amount of understanding among corporation health officials.

The disease pattern of the slum dwellers suggests that most of the problems are resulting from unsanitary environment, poor nutritional status and poor personal hygiene and low status of health awareness. To meet these basic needs certain amount of resources have to be spent. Imaginative schemes involving the slum dwellers need to be developed so as to improve the efficiency of such programmes. At present even the inadequate funds spent is not appreciated by slum dwellers and they have very little involvement with it. Problems of vulnerable groups such as women, aged, handicapped and chronically ill are not getting much attention from government. The government is not paying adequate attention to supporting the women, given their situation of being 'doubly exploited'. Active efforts towards education, supporting economic independence and changing the social status of women need to be undertaken. Instead some of the policies for example those leading to proliferation of alcohol shops, thoughtless demolitions of the dwellings are having the opposite effect.

The presently growing phenomenon of street children and rag pickers need official government provision and planning to integrate their life into the community, as this is arising out of the survival of strategies of the slum communities.

The NGO groups working with slum dwellers are not having much networking or coordination among themselves which could strengthen their efforts and understanding. Though NGO efforts have the advantage of working in a small area and the freedom to experiment and creatively respond to the needs of the people, a large percentage of their efforts seem to be directed at superficial symptoms rather than basic needs. Hence NGO groups developing a deeper perspective on the problem and coming together to work on an issue based level would be important. Active participation of NGOs in government programmes on an equal partnership basis need to be explored. There is a role for publicising studies showing effective work with slum dwellers which can help others to avoid some mistakes. Getting professionals interested and committed to supporting the efforts of the slum dwellers is important.

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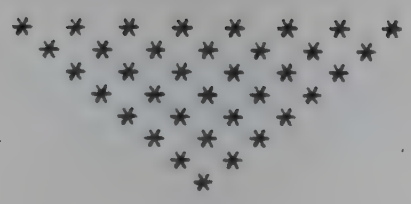
IN THE FINAL ANALYSIS, IT IS MY BELIEF THAT ENERGY FOR CHANGE WILL HAVE TO COME FROM THE PEOPLE THEMSELVES. HENCE PARTICIPATORY PROGRAMMES, PLANNED AND EXECUTED BY THE SLUM DWELLERS THEMSELVES WITH TECHNICAL AND OTHER SUPPORTS FROM THE GOVERNMENT AND NGOs WOULD BE IDEAL. BUT, AN OPENNESS ON THE PART OF GOVERNMENT i.e., OFFICIALS TO UNDERSTAND THE NEEDS AND DYNAMICS OF THE SLUM PEOPLE NEED TO BE FOSTERED.



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